Community Counseling Center
a program of
Catholic Community Services

3737 Portland Rd. NE
Salem, Oregon 97301
Ph: 503-390-2600
Fx: 503-304-1310
www.ccswv.org

INDIVIDUAL BASIC INFORMATION

☐ Child (5-13) ☐ Youth (14-18) ☐ Adult (18+) Today's Date ___________________________

Return Client? ☐ Yes ☐ No Year?___ Social Security #________________________

Marital Status:
☐ Single ☐ Married
☐ Domestic Partner

Military Status:
☐ N/A ☐No
☐ Yes

Primary Language:
☐ English ☐ Spanish
☐ Russian ☐ Other_______

Gender
☐ M ☐ F ☐T

Individual Full Legal Name (Birth name) Date of Birth

Address City State, Zip Code

Home Phone
OK to leave message? ☐ YES ☐ NO

Cell Phone
OK to leave message? ☐ YES ☐ NO

Email Address
OK to send message? ☐ YES ☐ NO

Email Address
OK to send message? ☐ YES ☐ NO

FAMILY, RELATIVES AND IMPORTANT PEOPLE INVOLVED IN YOUR LIFE

☐Emergency Contact's Name Relationship to Individual Phone

☐Legal Guardian's Name (If Applicant is Minor/ Adoptive) Relationship to applicant Phone

Address City, State, Zip Code Email Address OK to send appointment reminders? ? ☐ Yes ☐ No

INSURANCE/ PLAN/PAYOR (Please Provide ID Number)

☐WVCH_____________________☐DMAP_____________☐MEDICARE______________________
☐PRIVATE INSURANCE (Out of Network)________________________☐CASH________________

HIGHEST GRADE COMPLETED_______________ETHNICITY___________PREGNANT Y N
INCOME SOURCE: ☐ PUBLIC ASSISTANCE ☐ WAGES ☐OTHER
MONTHLY GROSS INCOME__________
TOTAL # IN HOUSEHOLD ___________CHILDREN IN HOUSEHOLD_______
EMPLOYMENT STATUS:
WORKING NOW : ALL THAT APPLY ☐YES ☐ F/T ☐ P/T ☐ STUDENT ☐ NO ☐ DISABLED/UNABLE

AGENCY/STATISTICAL (MOTS) INFORMATION

DIAGNOSIS:_______________________________APPT DATE: ___________________________
ASSIGNED THERAPIST________________________________ MOTS # (agency use):_______________________

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REQUIRED FOR MINORS UNDER 18

WHO LIVES IN YOUR HOME?

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

_______________________________________ ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
NAME RELATIONSHIP RATE THIS RELATIONSHIP

Collateral Program Involvement and Release of Information
We must have a release of information for anyone involved in your care.
Please see exceptions in our Policy Packet

☐ DHS Worker: ____________________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐ Probation Officer: _________________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐ New Solutions: ___________________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐ Attorney_________________________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐ CASA/GAL: ______________________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐PrimaryCarePhysician/Clinic::________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

☐CCS PROGRAM/CONTACT________________Phone:________________Email:________________
FAX: _____________________________________☐ Release Provided ☐ Expires: _______________

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Fee Schedule, Financial Agreement, Missed Appointment/Cancellation Policy

Individual Name: ____

Services	UNDERGRADUATE LEVEL QMHA/PEER SUPPORT SPECIALIST	UNDERGRADUATE LEVEL QMHP/BACHELOR	GRADUATE LEVEL QMHP/MASTERS	LICENSED PRACTITIONER
	IN-CLINIC/OUT-OF-CLINIC	*IN-CLINIC/OUT-OF-CLINIC*	*IN-CLINIC/OUT-OF-CLINIC*	*IN-CLINIC/OUT-OF-CLINIC*
MENTAL HEATH ASSESSMENT OR PROGRAM SCREENING	$28.51	$140.31-$200.56	$140.31-$200.56	$187.07-$324.96
INDIVIDUAL THERAPY	$21.93-$48.28	$21.93-$48.28	$21.93-$48.28	$31.89-$108.32
GROUP OR ACTIVITY THERAPY	$10.18-$48.28	$57.50-$66.23	$57.50-$66.23	$57.60-$216.65
FAMILY THERAPY	$21.93-$30.08	$158.49-$200.56	$158.49-$200.56	$57.60-$216.65
CASE MANAGEMENT	$20.37-$48.28	$28.78-$48.28	$28.78-$48.28	$28.78-$151.65
PSYCHOTHERAPY CRISIS INTERVENTION	~	$28.78-$48.28	$28.78-$48.28	$46.42-$225.55
PSYCHIATRIC SERVICES				
MEDICATION MANAGEMENT OR TRAINING	$20.37-$48.28	$20.37-$48.28	$20.37-$48.28	$187.07-$275.00
PSYCHIATRIC EVALUATION	~	~	~	$248.59-$338.34
PSYCHIATRIC EVAL W/ MEDICAL SVCS	~	~	~	$279.15-$338.34
PSYCHOLOGICAL TESTING AND REPORTING	~	~	~	$115.75-$216.65
RETURNED CHECK FEE(CASH)	~	$30.00	~	~

Financial Agreement:
I understand I am responsible for my treatment costs. I understand that my private insurance or Oregon Health Plan may cover any medically necessary treatment; however I am solely responsible for the cost of my treatment. If my private insurance or Oregon Health Plan lapses during the course of treatment, I understand that I am responsible for any balance. I understand that if this occurs, it is also my responsibility to immediately notify the office staff. By notifying staff of my loss of eligibility, I understand that this allow staff to assist me in exploring alternate methods of payment for my services. I also understand that if I am referred for legal reasons and there is no medical necessity, I am responsible to pay for the treatment.

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I understand I am responsible to bring a copy of the OHP card I am issued to each appointment, whether individual, family, or group. I understand it is my responsibility to make sure I have a current card. I understand I am to bring any copay for my private insurance or the fee for the visit for payment at that time of that visit. If I am unable to pay the agreed upon amount, I will attempt to arrange a payment plan. If I do not adhere to this payment plan, I understand I may not receive services until I bring my account up to date.

I understand that successful completion of the program includes completing any financial responsibility in keeping with the Oregon Administrative Rules. CCC will work with me to create a payment plan if necessary once treatment has begun.

It is the intent of Behavioral Health Services to create an atmosphere in which the individual is able to demonstrate financial responsibility and to not create barriers to treatment. Studies have shown that those individuals who are responsible in paying for their treatment have a better chance of being successful.

My payment plan (check one):

☐ I have the Oregon Health Plan. I understand that if my medical card is not valid, I am financially responsible for the visit.

☐ I have private insurance and will pay the balance for which I am responsible.

☐ I have a voucher entitling me to services.

☐ I am paying cash for my or my dependent's treatment.

Individualized payment plan:____

____

____

Missed Appointment/Cancellation Agreement:

I understand that if I am unable to keep my scheduled appointment that is my responsibility to call and cancel with at least 24-hour notice. I understand that if I have three or more cancelled or missed appointments, within a 90 day period, that this may result in the inability for CCC to continue to provide service to me. I understand that this may require a review to be conducted by my therapist, and the clinical supervisor, to determine if my continued enrollment in services is appropriate. I understand that this may result in my services being terminated and that a letter will be sent to notify me.

I have read the above fee schedule, financial agreement, and missed appointment/cancellation agreement and agree to the financial policies of Behavioral Health Services. I also agree to the payment plan, as indicated above. I have been given a copy of the Fee Schedule, Financial Agreement and the Missed Appointment/ Cancellation Agreement.

Signature of Individual_____________________________________ Date__________________

If Minor, Legal Guardian____________________________________ Date__________________

CCC Representative____ Date__________________

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CONFIDENTIALITY STATEMENT & CONSENT TO TREATMENT

Oregon Health Plan and Private Insurance Members: If you request your insurance company pay for your treatment, you are giving permission to provide them with information about you, including your clinical diagnosis. Services to Oregon Health Plan members are provided through our contract with the Mid-Valley Behavioral Care Network (MVBCN), through Out-Of-Panel agreement with Family Care, and other private insurance companies, although we are not a preferred provider. These entities recognize and will honor the personal and private nature of your health information. If you need service from more than one network provider, we may need to share limited information to provide you with the best of care. We will allow sharing of limited data, such as dates of service, therapist's name, diagnosis, medications, etc., on a "need to know" basis, to coordinate care among multiple providers, when in your best interest.

> ***If you are an Oregon Health Plan recipient, we are required by law to share limited information such as your diagnosis, medication prescribed, and expected length of service with your primary care physician.***

Confidentiality:
Individuals receiving services from Behavioral Health Services may include adults, parents or guardians and children, and youth of at least 14 years of age who independently request services. In general, any information we have about individuals receiving services is confidential and will not be disclosed without the individual's written permission. That means what you tell us is private. Written clinical records are to receive the highest level of protection, and are to be released only upon specific written consent from the individual or their representative. When you ask that we communicate with anyone about you, we will ask that you sign a written release to allow the sharing of specific information. In an urgent situation, we will honor your verbal release, as documented in the clinical record, for the verbal sharing of information, to facilitate care coordination.

Catholic Community Services operates several programs, including Community Counseling Center, Mentoring, Foster services and Family Support Services. When applicable, information may be shared among providers in these programs to provide you with the best in coordinated care. We operate as a team and provide each other with consultation.

Exceptions to Confidentiality: Please read these items carefully

- All Catholic Community Services employees are required to report to government agencies any suspicion of abuse or neglect of a child, elderly person, or vulnerable person as defined by Oregon State Law.
- For all OHP recipients Catholic Community Services is required by law to share limited information such as your diagnosis, medication prescribed, and expected length of service with your primary care physician.
- Records may be subpoenaed. When appropriate, we will attempt to talk with you if we receive a subpoena. A court may force us to release your records, even if you are opposed to the release.
- A non-custodial parent may have the right to review records or discuss their child's treatment with the therapist.
- If we have reason to believe an individual intends to harm themselves or someone else, we may notify a family member, the police, or other persons who may protect them.

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- If we believe an individual intends to commit an act of violence, we may inform the intended victim, police or others who can prevent the violence.
- If an individual commits a crime against a Catholic Community Services staff member or property, the individual's name may be released to the police.
- Therapists at Catholic Community Services discuss clients with supervisors, consultants, and other staff members. The supervisors of graduate students may be faculty members of the university at which the student is enrolled.

Informed Consent to Treatment:

Behavioral Health Services provides outpatient counseling and treatment to children, adults, and families. Our service providers are trained professionals or graduate student interns who are completing advanced degrees in their profession. Supervision is provided to the counseling and treatment staff by qualified, experienced professionals. Your service provider can tell you about his / her professional background and training and can provide you with their personal disclosure statement.

Although many people have been successfully treated by Catholic Community Services, not everyone will benefit from our services. As such, we cannot guarantee a successful outcome. If we believe a person will not benefit from our services or we are unable to provide a service in a timely manner, we will discuss the matter and provide referrals when possible. Alternatives to treatment at this agency may include referral to another outpatient agency, services provided in schools, day treatment, or residential treatment.

There are some risks associated with engaging in mental health treatment. Sometimes, emotional or behavioral problems worsen temporarily. This can be a normal part of the process, and is something you should discuss with your therapist, if it occurs. Additionally, family members may experience increased stress or discomfort as relationships and problems are discussed.

ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION FOR SERVICES

- ✓ Confidentiality Statement and Informed Consent To Treatment
- ✓ Fee Schedule, Financial Agreement, Missed Appointment/Cancellation Policy
- ✓ Individual Complaint Policy
- ✓ Individual Expectations
- ✓ Individual Rights Policy
- ✓ Notice of Privacy Practices

I agree with and acknowledge that I have received copies of Catholic Community Services' Community Counseling Center's policies and consent forms listed above and I have read the above documents and/or a representative has explained them to me.

Signature ____ Date ________________________

If Minor, Legal Guardian ____________________________ Date ________________________

Staff Signature ____________________________________ Date ________________________

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HEALTH HISTORY QUESTIONNAIRE

Name: ____ Date: _______________

NOTE: This health history is designed to help us gather information so that the staff can work together with you in developing a program that works for you. The first step in that process is taking an immediate "inventory" on your health. **ALL INFORMATION GIVEN WILL BE KEPT STRICTLY CONFIDENTIAL**. Please answer all the questions to the best of your abilities.

Primary Care Physician: ____
Address: ____
Phone: _____________________________________ Fax: ___________________________________

Does the individual have allergies, a history of reactions to medications or other emergency health needs? ☐ No ☐ Yes, please describe: ____
____

HEALTH HISTORY:

When did you last have a physical? ____
What is your dentist's name? ____
In what city is your dentist's office? ____
How would you rate your general health at this time? (check one)
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Are you currently taking any medications (including psychotropic): ☐ No ☐ Yes (Please list)

Name of Medication:	Dosage (amount and times):	What is the drug treating?	Prescriber of medication:

Are you pregnant? ____
Are you overweight? _______________ If yes, how many pounds? ____________________________
Your height: ____________ Your weight now: __________ One year ago: ______________________
Do you smoke or use nicotine? ____
If yes, how much or how many cigarettes per day? ____
Are your veins difficult to draw blood from? ____
List any surgeries you have had: ____
____
List any hospitalizations you have had: ____
____
Other than above, have you ever been seriously ill or injured? _______________________________
If so, please describe: ____
____

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FAMILY HISTORY:

Please check here if any of your family members have had any of the following conditions and identify who had those conditions (father's mother, mother's mother, father's father, mother's father, father, mother, brother, sister, children, etc.)

- ❑ Alcoholism: ____________________
- ❑ Bleeding problems: ____________________
- ❑ Cancer: ____________________
- ❑ Diabetes: ____________________
- ❑ Drug problems: ____________________
- ❑ Depression: ____________________
- ❑ Heart attack: ____________________
- ❑ High blood pressure: ____________________
- ❑ Hospitalization for mental / emotional problems: ____________________
- ❑ Mental disorders: ____________________
- ❑ Psychiatric treatment: ____________________
- ❑ Stroke: ____________________
- ❑ Suicide or attempt: ____________________
- ❑ Tuberculosis: ____________________

Within the last 30 days, have you had any of the following conditions?

- ❑ Abscess or skin sores
- ❑ Brownish colored urine
- ❑ Tarry or black stool
- ❑ Bruises / wounds that won't heal
- ❑ Cramps in stomach or bowels
- ❑ Shortness of breath
- ❑ Donated plasma or been refused as a donor
- ❑ Night sweats
- ❑ Disturbed sleep
- ❑ Fatigue / lack of energy
- ❑ "fix" (drug) dreams
- ❑ skin rash
- ❑ fever or chills
- ❑ cold or flu
- ❑ painful intercourse
- ❑ Mental confusion
- ❑ Nosebleed
- ❑ Jaundice (yellowish skin or eyeballs)
- ❑ Sudden memory loss / amnesia
- ❑ Red streaks along vein
- ❑ Double vision
- ❑ Suspicious of other people
- ❑ Ringing in ears
- ❑ Thoughts of killing / harming self
- ❑ Thoughts of killing / harming others
- ❑ Nausea / vomiting
- ❑ Swollen glands
- ❑ Light / pale colored stool
- ❑ Tenderness in breasts
- ❑ Nasal discharge / runny nose
- ❑ Seizure or convulsions
- ❑ Tremors / shakes / shuddering
- ❑ Excessive sweating
- ❑ Watery eyes
- ❑ Nightmares
- ❑ Drug overdose
- ❑ Loss of consciousness
- ❑ Hallucinations
- ❑ Diarrhea
- ❑ Suicide attempt
- ❑ Itching / crawling skin
- ❑ Sexual assault / abuse
- ❑ Fight or accident
- ❑ Fear of other people
- ❑ Unusual drug reaction
- ❑ Late / missed menstrual period
- ❑ Lack of sleep for more than 3 consecutive days
- ❑ Shared a needle with someone else
- ❑ Muscle cramps
- ❑ Missed vein while injecting drugs

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Please check here if you have ever had any of the following conditions:

- ❑ Anemia
- ❑ Seizure or Convulsions
- ❑ Blackouts
- ❑ Serious fight / accident injury
- ❑ Bleeding problems
- ❑ Severe withdrawal symptoms
- ❑ Bowel trouble
- ❑ Stomach trouble
- ❑ Cancer
- ❑ Suicide attempt
- ❑ Eating disorder
- ❑ Abortion / miscarriage (females)
- ❑ Epilepsy
- ❑ Venereal disease
- ❑ Heart trouble
- ❑ Tuberculosis
- ❑ Joint/ muscle problems
- ❑ Palpitations or "pounding" heart
- ❑ Thyroid problems
- ❑ Lung / breathing problems
- ❑ Problems with "nerves"
- ❑ Eye trouble
- ❑ Double vision or blindness
- ❑ Hernia
- ❑ Glaucoma or cataract
- ❑ Kidney disease or malfunction
- ❑ Dental problems
- ❑ PMS
- ❑ Loss of consciousness
- ❑ Pregnancy
- ❑ Asthma
- ❑ Allergic to bee stings
- ❑ Epilepsy seizures
- ❑ Victim of rape / incest / sexual abuse
- ❑ Victim of physical abuse
- ❑ Chest pressure or chest pain
- ❑ Jaundice
- ❑ Diabetes
- ❑ Urinary problems
- ❑ Difficulty sleeping
- ❑ Weight problems
- ❑ Depression
- ❑ Chronic cough
- ❑ Prostate trouble (males)
- ❑ Rheumatic fever
- ❑ Drug overdose
- ❑ Cesarean birth (females)
- ❑ Uterine / ovarian problems (females)
- ❑ High blood pressure
- ❑ Rheumatic fever / heart murmur
- ❑ Disease of stomach or intestine
- ❑ Ear, nose, or throat problems
- ❑ Difficulty hearing
- ❑ Stomach ulcers
- ❑ Hepatitis or liver disease
- ❑ Frequent or severe headaches
- ❑ Head injury
- ❑ Nervous trouble of any kind
- ❑ Diseases of skin, hives, eczema, infections
- ❑ Dizziness or fainting spells
- ❑ Foot trouble
- ❑ Back injury or lower back pain
- ❑ Shortness of breath
- ❑ Coughing blood
- ❑ Other health problems

TO BE FILLED OUT BY PARENTS, FOR THEIR CHILDREN BETWEEN AGES 4-7 YEARS.
TO BE FILLED OUT BY CHILD/ADOLESCENTS AGES 8-17.

CATHOLIC COMMUNITY SERVICES ■ BEHAVIORAL HEALTH SERVICES

CLIENT NAME:________________________________ AGE:________ DATE:____________

UCLA PTSD Reaction Index Trauma Screen – Child Completed (Ages 4-17)*

Below is a list of scary, dangerous or violent situations or events that sometimes happen to kids.
Please mark YES if you did experience or witness the event.
Mark NO if this did not happen to you.

1 □Yes □ No Being in a big earthquake that badly damaged the building you were in.
2 □Yes □ No Being in another kind of disaster, like a fire, tornado, hurricane or flood.
3 □Yes □ No Being in a bad accident, like a very serious car accident.
4 □Yes □ No Being in a place where war was going on around you.
5 □Yes □ No Being hit, kicked, or punched very hard at home (DO NOT include ordinary fights with brothers or sisters).
6 □Yes □ No Seeing a family member being hit, punched or kicked very hard at home (DO NOT include ordinary fights with siblings)
7 □Yes □ No Being beaten up, shot at or being threatened to be hurt badly.
8 □Yes □ No Seeing someone in real life being beaten up, shot at, hurt badly, killed or almost killed.
9 □Yes □ No Seeing a dead body in real life (DO NOT include funerals).
10 □Yes □ No Having an adult or someone much older touch your private sexual body parts when you did no want them to or anyone forcing sex on you.
11 □Yes □ No Hearing about the violent death or serious injury of a loved one.
12 □Yes □ No Having painful and scary medical treatment in a hospital when you were very badly sick or injured.

13. Of the questions you marked YES, which one do you think was the worst?
(Please list the number) _____

14. Of the questions, which one do you think is the reason you are here?
(Please list the number) _____

Please check YES or NO to answer how you felt during the event you indicated in Question 14:

1. Were you scared you would die? □Yes □ No
2. Were you scared you would be hurt badly? □Yes □ No
3. Were you hurt badly? □Yes □ No
4. Were you scared someone else would die? □Yes □ No
5. Were you scared that someone else would be hurt badly? □Yes □ No
6. Was someone else hurt badly? □Yes □ No
7. Did someone die? □Yes □ No

Used with permission from: UCLA PTSD Index Pynoos, Rodriguez, Steinberg, Stuber, & Frederick; CPSS Foa, Johnson, Feeny, and Treadwell (2001)

TO BE FILLED OUT BY PARENT/GUARDIANS

CATHOLIC COMMUNITY SERVICES ■ BEHAVIORAL HEALTH SERVICES

Child's Name:_________________________________ Child Age:________ Date: _____________

Parent/Guardian Completing Form:_______________________________

Child PTSD Symptom Scale CPSS (4-17 years) -- Parent Completed

Please rate, as best you can, how often the following things have bothered your child in the last few weeks:

0 Not at all
1 Once per week or less/ a little bit/ once in a while
2 2 to 4 times per week/somewhat/half the time
3 5 or more times per week/very much/almost always

0 1 2 3 1. Your child having unwanted, upsetting thoughts or images about the traumatic event

0 1 2 3 2. Your child having bad dreams or nightmares

0 1 2 3 3. Your child acting or feeling as if the events happened again

0 1 2 3 4. Your child feeling upset when s/he thinks about or hears about the event

0 1 2 3 5. Your child having feelings in their body when thinking or hearing about the event (heart beating fast, upset stomach, breaking out in a sweat)

0 1 2 3 6. Your child trying not to think about, talk about or have feelings about the event

0 1 2 3 7. Your child trying to avoid activities or people or places that remind you of the event

0 1 2 3 8. Your child not being able to remember an important part of the upsetting event

0 1 2 3 9. Your child having much less interest or not doing the things s/he used to do

0 1 2 3 10. Your child not feeling too close to the people around him/her

0 1 2 3 11. Your child not being able to have strong feelings (being able to cry or feel really happy)

0 1 2 3 12. Your child feeling as if his/her future hopes or plans will not come true

0 1 2 3 13. Your child having trouble falling or staying asleep

0 1 2 3 14. Your child feeling irritable or having fits of anger

0 1 2 3 15. Your child having trouble concentrating

0 1 2 3 16. Your child being overly careful (checking to see who is around)

0 1 2 3 17. Your child being jumpy or easily startled

(continue on other side…)

Please mark YES or NO if the problems above interfered with the following for your child:

1. Saying prayers ☐Yes ☐ No
2. Doing chores ☐Yes ☐ No
3. Friendships ☐Yes ☐ No
4. Hobbies/Fun ☐Yes ☐ No
5. Schoolwork ☐Yes ☐ No
6. Family relationships ☐Yes ☐ No
7. General happiness ☐Yes ☐ No

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Authorization to Release and/or Obtain Information

Individual Name: ____ DOB: ______________ SS# ____________________

I authorize Catholic Community Services Behavioral Health to share information with the following person:

Name: ____ Organization: ________________________________

Address: ____

Phone: ____ FAX: ____

I give my permission to share the following information (please **INITIAL** either yes or no)

___ Yes ___ No Medical, social educational, psychological reports
___ Yes ___ No Results of current or past treatment
___ Yes ___ No Information about court proceedings
___ Yes ___ No Information about drug and alcohol treatment
___ Yes ___ No Other (Specify):____

Please initial one of these boxes if this applies:
____ I understand that I may choose not to sign this authorization and that my choice not to sign will not affect my ability to obtain treatment or payment or my eligibility for health care benefits.

____ I understand that CCS has been asked to provide a health care service to me (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if I choose not to authorize the disclosure of that information to the other person, then CCS may not provide that health care service to me.

Reason for sharing information:

___ Yes ___ No Diagnosis and assessment ___ Yes ___ No Treatment Planning

___ Yes ___ No Other (Specify)____

This authorization is good until:_______ / _______ / _________ (This date is not to exceed one year from date of signature or three months from date of signature if no further contact will be made)
Month Day Year

I can cancel permission to use and disclose my information at any time in writing. Permission to use and disclose my treatment records can be canceled by talking with my counselor. I understand this change will not affect information that has already been shared. I understand that my records are protected under the federal confidentiality regulation (42 CFR Part 2) (ORS 179.495) and can not be disclosed without my written consent. Under the Federal Act of July 8, 1987 confidentiality of Alcohol and Drug Abuse patient records, no such records, nor information from such records may be further disclosed without specific authorization for redisclosure. I understand that they cannot share information listed in the Important Note section unless I give them permission.

____ ____________________
Signature of Individual Date

____ ____________________
Signature of Legal Guardian if individual is a minor Date

____ ____________________
Signature of CCS representative Date

____ ____________________
Signature of Staff Person Making Copies Date

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Important note: Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

1. **HIV:** No one can disclose or require you to disclose your HIV test results, except as required or permitted by federal or state law or rule, or with your written permission. To release your results, this authorization must include a statement in the "Special Information to be Disclosed" section that you agree that your "HIV test information may be released." All HIV test information released must be labeled with a statement that: "This information may not be disclosed to anyone without the specific written authorization of the individual." Redisclosure of HIV test information is not allowed, except in compliance with law, or with your written permission.

2. **Alcohol and Drug Treatment:** Alcohol and/or drug treatment records are protected under the federal regulations and cannot be disclosed without your written authorization unless otherwise provided in that regulation. The "Specific information to be Disclosed" section of this form should describe the specific dins and amount of information to be disclosed with enough detail (such as "assessment, treatment plan, attendance, discharge plan" so that the program can provide the information. Redisclosure of your alcohol and/or drug treatment records is not allowed, except in compliance with law or with your written permission.

3. **Mental Health Treatment:** Mental health treatment records are protected under state law and cannot be disclosed without your written authorization, unless otherwise allowed in state or federal law or regulation. The "Specific Information to be Disclosed" section of this form should describe the nature and extent of information to be disclosed with enough detail (such as "assessment, treatment plan, attendance, discharge plan") so that the program can provide the information. Also, disclosure of your therapist's own notes ("psychotherapy notes") need separate permission. Redisclosure of your mental health treatment records is prohibited, except in compliance with the law or with your written permission.

4. **Genetic Information:** THIS FORM IS NOT SUFFICIENT TO AUTHORIZE THE USE OR DISCLOSURE OF GENETIC INFORMATION. State law (ORS 192.531 – 192.539 and OAR 33-025-0140 through – 0160) says that genetic information can be shared with the written permission of the individual using a specific form. You can get a form for the use or disclosure of genetic information from DHS Public Health Services.

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PRE-SERVICE SURVEY

Individual Name_________________________________ **Date**_______________

1. When did you last use alcohol, marijuana, or other drugs? ________________________

2. When did you first use alcohol or drugs on your own, away from family or caregivers?____

3. How often do you use alcohol or drugs?______________________________________

4. How often have you been drunk or high?______________________________________

5. Has your alcohol or drug use caused problems with your friendships, family, school, or community? ☐ Yes ☐ No

6. Have your grades slipped? ☐ Yes ☐ No

7. Have you had problems with the law? ☐ Yes ☐ No

8. Are you concerned about your alcohol/drug/marijuana use? ☐ Yes ☐ No

9. Have you tried to quit or cut down? ☐ Yes ☐ No

   What happened?____

10. During the past 12 months, have you become restless, irritable or anxious when trying to stop/cut down on gambling? ☐ Yes ☐ No

11. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled? ☐ Yes ☐ No

12. During the past 12 months, did you have such financial trouble that you had to get help with living expenses from family, friends, or welfare? ☐ Yes ☐ No

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PRE-SERVICE SURVEY FOR PARENTS/GUARDIANS OF YOUTH

Youth's Name_______________________________________ **Date**_______________
Name of Parent/Guardian____

1. Do you know/suspect your child is using drugs or alcohol? ☐ Yes ☐ No

2. Has your child's behavior changed significantly in the past six months (sneaky, secretive, isolating, assaultive, aggressive, hostile, etc.)? ☐ Yes ☐ No

3. Has the school, community, or legal system expressed concerns regarding your child? ☐ Yes ☐ No

4. Has there been a marked fall in academic/extracurricular performance? ☐ Yes ☐ No

5. Are you concerned about a change in your child's peer group? ☐ Yes ☐ No

6. Do you believe an alcohol/drug assessment might be helpful? ☐ Yes ☐ No

7. During the past 12 months, has your child become restless, irritable or anxious when trying to stop/cut down on gambling? ☐ Yes ☐ No

8. During the past 12 months, has your child tried to keep their family or friends from knowing how much they gambled? ☐ Yes ☐ No

9. During the past 12 months, did your child have such financial trouble that they had to get help with living expenses from family, friends, or welfare? ☐ Yes ☐ No